

Case: 2:06cv304

✓ Francis A. Grandinetti II AIS#035;185087
✓ CCA/TCCF Contractor #1403
✓ 295 U.S. Hwy. 49 South
✓ Tutwiler, MS 38963-5072

MS#223000

TO ATTORNEYS OF RECORD: Electronic Noticing is MANDATORY in the District Court for the Middle District of Alabama.

By order of the court (General order 04-3164) Electronic Noticing is mandatory for all attorneys who wish to practice in this district.

ATTORNEYS, If you have received this notice by mail, you have not yet complied with this order, according to our records. Please register IMMEDIATELY!

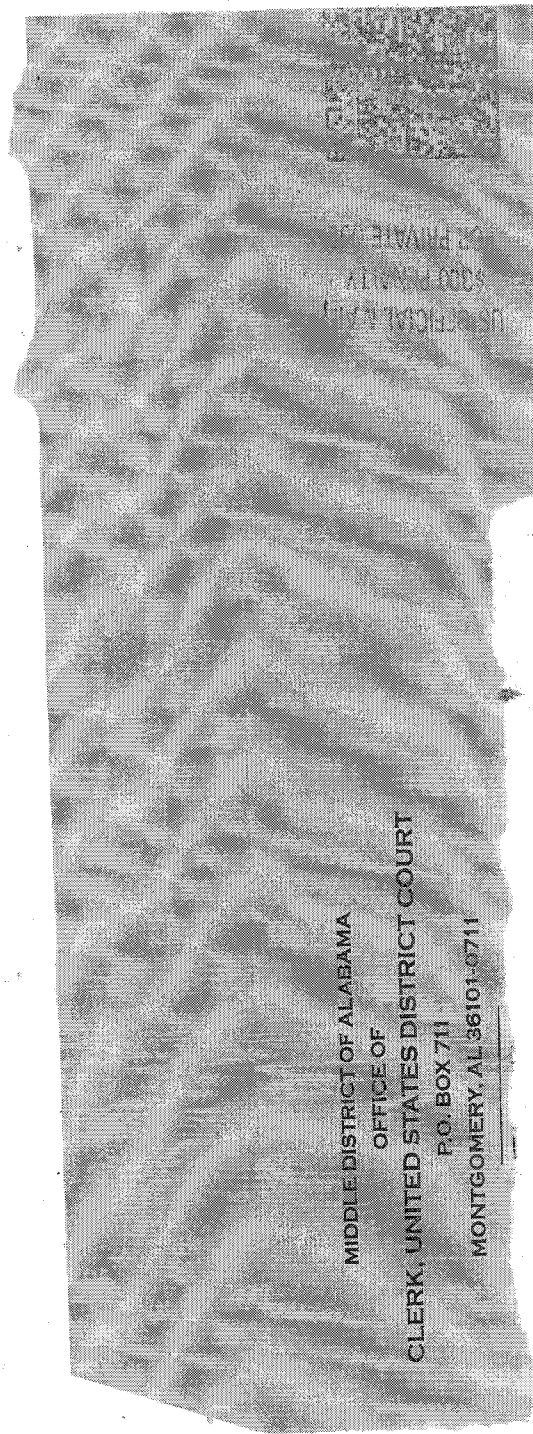
The mandatory registration form for attorneys can be accessed through our web site (www.almd.uscourts.gov, click on the CM/ECF icon. At the CM/ECF welcome page, click on the Registration button). The form can be completed and submitted on-line

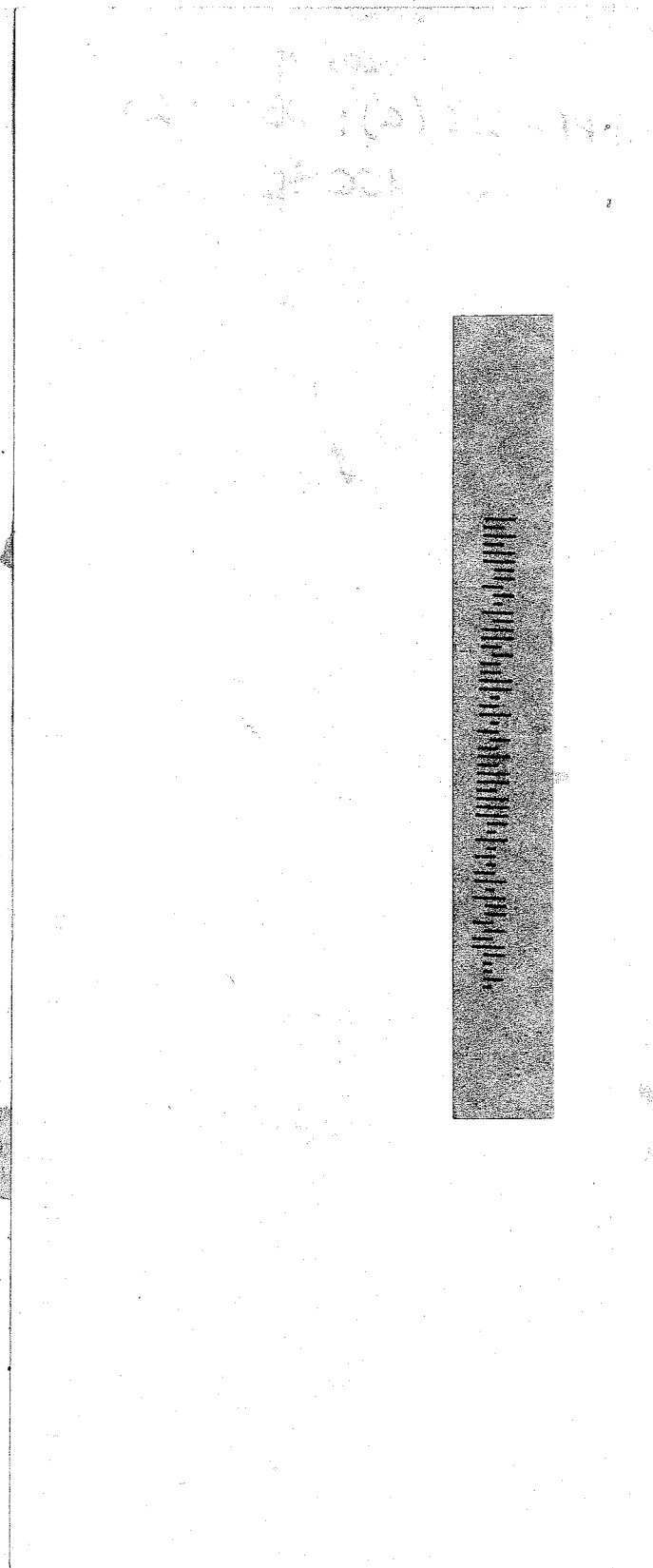
If you have any questions or need help with our Case Management/Electronic Case Files (CM/ECF) system, please call our help desk on 334.954.3935.

Received Doc. Nos. 71 and 81 by mail,
on March 29, 2007, Thursday.

X Francis A. Grandinetti II, aka

(Proof of Service.)





[illegible]

This micrograph shows a cross-section of a polymer matrix with numerous small, dark, dispersed particles. The particles are distributed throughout the matrix, which appears as a lighter, textured background. The overall appearance is granular and heterogeneous.

2:06-CV-304-MHT

Sick Call Request (Co-Pay)

Part A: (to be completed by inmate/resident)

Work Assignment:

Work Hours:

Housing Assignment:

Reason for requesting Health Services Appointment (BE SPECIFIC):

by CCA Staff, on 09/14/04, Cooke, Bradley, etc.
Lots of bumps on head, dizzy.

How long have you had this problem?

Inmate (Print Name):

Inmate Number:

Inmate/Resident Signature:

Date:

Part B: (Medical Staff Only)

Services and Meds Provided:

Health Services Signature:

Date:

Charge Receipt**Part C:** (to be completed by inmate/resident)

Inmate Name (Print):

Inmate Number:

Date:

Work Assignment:

Work Hours:

Housing Assignment:

I understand that in accordance with State Law, I will be charged for each chargeable medical/psychiatric/dental service I receive and for each chargeable medication ordered. I also understand that if the Facility determines I am indigent or funds become available.

This request authorizes disbursement from my trust fund account.

Inmate/Resident Signature:

Date:

Part D: (to be completed by Medical Staff)

Charges:

The inmate/resident received chargeable medical services @ \$ _____ \$ _____

The inmate/resident received chargeable psychiatric services @ \$ _____ \$ _____

The inmate/resident received chargeable dental services @ \$ _____ \$ _____

The inmate/resident received _____ medications @ \$ _____ each \$ _____

Health Services Initials: _____

White: Medical Records

Yellow: Parts C & D - Business Office

Pink: Inmate/Resident